Independent Advisory Group
for Sexual Health and HIV

ANNUAL REPORT
2003/04

Independent Advisory Group for Sexual Health and HIV

The Independent Advisory Group (IAG) for Sexual Health and HIV was established in 2003 as part of the Implementation Action Plan for the National Strategy for Sexual Health and HIV

The IAG was set up to monitor progress and advise Government on implementation of the Strategy, including any further action necessary to achieve the Strategy's aims.

Through its work the IAG aims to raise the profile and priority of sexual health. The IAG advises on areas for improvement, identifies undeveloped policy areas and barriers which stand in the way of the Strategy's implementation, and highlights solutions such as best practice work and innovation.

The Government's National Strategy for Sexual Health and HIV defines sexual health as follows:

"Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease."

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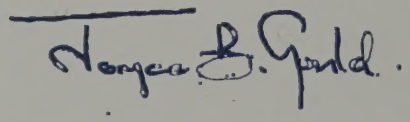
1 Foreword

"The Independent Advisory Group for Sexual Health and HIV believes that sexual health should be considered holistically as part of the public health agenda. Sexual health issues cut across many areas of public health and affect the entire population.

In its first year, the Independent Advisory Group for Sexual Health and HIV has taken a hard look at the way sexual health is approached in this country. We have concentrated on the various platforms for healthcare delivery – prevention and education, the standards of care, and research and epidemiology.

In this, our first Annual Report, we present our early findings and a series of recommendations. These recommendations outline not only what the Government can do to tackle rapidly emerging problems, but also work that general practices, Primary Care Trusts (PCTs), healthcare organisations and individuals can do. Not all recommendations have price tags attached.

It is time to recognise that good education, services and support will not only help improve people's sexual health, but also impact on their overall physical and mental well-being. More importantly, we need to recognise the significant impact of poor sexual health in terms of social, behavioural and financial considerations. Some believe sexual health issues to be a kind of Pandora's box of sins unleashed on a permissive society. It's time to destigmatise sexual health and properly deal with what is and will continue to be a very real consideration for public health."



Baroness Joyce Gould
Chair, Independent Advisory Group
for Sexual Health and HIV

"Our method has been to look at the problem from all angles – from prevention and diagnosis through to treatment and long-term care – and to look closely. Our work has taken us into areas such as specific problems with HIV and how sexual health affects black and minority ethnic communities."

2 Introduction

2.1 The current situation

In order to understand the scope of the IAG's remit and to put this report in context, it is important to remind ourselves of the scale of the sexual health problem in the UK. Diagnoses of sexually transmitted infections (STIs) – including HIV – are soaring, despite recent reductions the UK still has the highest teenage pregnancy rate in Western Europe, and there are significant variations in abortion services both in terms of waiting times and NHS funding.

Diagnoses of STIs – including HIV – are soaring. Despite recent reductions the UK still has the highest teenage pregnancy rate in Western Europe, and there are significant variations in abortion services both in terms of waiting times and NHS funding. In 2003 there were over 2 million new episodes seen in UK genitourinary medicine (GUM) clinics, and over 670,000 new STIs were diagnosed in GUM clinics in England alone. In the period 1995-2003, in England, Wales and Northern Ireland, total diagnoses of STIs have increased by 57%, and total workload has increased by 226%. During this period there have been particular increases in syphilis (1389%), chlamydia (193%), and gonorrhoea (137%)[1]. Moreover, these figures exclude most or all STIs recorded in primary care and are therefore an underestimate of the total.

Waiting times at GUM clinics in England are also problematic with access pressures being faced by patients and GUM clinics.

There have also been significant increases in HIV. Direct prevalence estimates indicate that by the end of 2002 an estimated 43,500 people were living with HIV in England, of whom an estimated 33% remain undiagnosed. There has been an increase of 126% in the number of people diagnosed as HIV positive since the mid-1990s, whilst more effective treatment has meant that the number of people living with HIV has also increased sharply over recent years. It is now the fastest growing serious health condition in England. Increasingly, the transmission of HIV infection in Africa between heterosexuals is impacting on new diagnoses in the UK, accounting for around 2,500 diagnoses in 2002.

Teenage pregnancy remains a significant public health problem in England, despite a reduction of 9.4% in under-18 conceptions since 1998. Teenage pregnancy rates are still the highest in Western Europe, and there are particular concerns about the high prevalence of teenage conceptions in London compared with the rest of the country.

STI diagnoses in England 1995–2003

	Number of annual cases			% increase	
	1995	**2002**	**2003**	**1995–2003**	**2002–2003**
All STI diagnoses	428,575	645,853	674,827	57%	4%
Syphilis	102	1,199	1,519	1,389%	28%
Chlamydia	29,241	78,489	85,550	193%	9%
Gonorrhoea	9,950	24,504	23,584	137%	-3%
Genital warts	51,236	64,118	65,414	28%	2%
Genital Herpes	15,021	17,569	17,173	14%	-2%

[1] Health Protection Agency – Summary table of selected conditions and total diagnoses/workload by sex: England, Wales and Northern Ireland, 1995–2003

New diagnosis of HIV in the UK by infection route, sex and year of diagnosis: data to the end of March 2004

How the infection was probably acquired	Sex	<1994	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004 J – M	Total
Sex between men	M	15,944	1,485	1,475	1,552	1,408	1,369	1,363	1,514	1,758	1,795	1,641	178	**31,482**
Sex between men	M	1,783	353	388	358	451	519	600	757	1,067	1,289	1,172	83	**8,820**
and women	F	2,024	442	465	479	557	644	832	1,245	1,809	2,200	2199	152	**13,048**
Injecting drug use	M	1,842	121	123	118	121	96	77	72	97	81	65	8	**2,821**
	F	858	46	59	54	48	35	34	39	36	26	32	2	**1,269**
Receiving blood	M	1,419	9	12	10	16	4	10	9	14	14	11	–	**1,528**
or blood products	F	116	8	8	11	13	6	11	15	11	16	12	1	**228**
Mother to infant	M	116	34	32	29	51	47	37	54	52	48	61	6	**567**
	F	126	32	28	33	33	50	42	49	40	49	55	5	**542**
Other	M	9	2	2	2	1	2	6	3	7	2	1	–	**37**
	F	13	–	2	1	–	2	2	3	–	4	2	–	**29**
Undetermined	M	430	27	34	27	24	22	21	20	18	18	9	–	**650**
	F	50	3	3	6	6	9	4	3	2	3	2	–	**91**
Follow-up ongoing	M	89	10	16	16	12	20	28	36	82	189	301	72	**871**
	F	21	4	4	3	7	8	12	27	45	208	301	45	**685**
Total†		**24,840**	**2,567**	**2,661**	**2,699**	**2,748**	**2,833**	**3,079**	**3,846**	**5,038**	**5,942**	**5,864**	**552**	**62,668**

*Numbers will rise as further reports are received

†Forty one people whose sex was not reported were excluded: seven infected through men and women, three blood recipients, two infected through mother to infant transmission, and twenty nine for whom the likely route of infection is not known.

There are still significant variations in abortion services in England and Wales, and waiting times in many areas are unacceptably long. In 2003, 80% of abortions were funded by the NHS, but 2002 figures show that while in some Primary Care Trust (PCT) areas almost all abortions are NHS-funded, in others less than two-thirds are funded by the NHS. There are also particular variations between PCTs in the number of NHS-funded abortions which take place under 10 weeks, which range from as low as 9% to as high as 75% in some areas[2].

The picture in relation to access to contraception is less easy to establish. We lack basic information about the current availability of the range of methods at national or local level. However, we know that many general practices – where the majority of contraceptive care is delivered – do not provide all methods of contraception, and there are particular concerns about access to longer-acting methods of contraception, especially those which require additional training to insert such as intrauterine devices (IUDs), intrauterine systems (IUSs), and implants.

In recognition of the enormity of the problem the National Strategy for Sexual Health and HIV was established in 2001, followed by an Implementation Action Plan. The seriousness of the issue was further highlighted by the House of Commons Health Select Committee, which produced a Report on Sexual Health in 2003 which described the current situation as nothing short of a "crisis".

[2] Government Statistical Service, *Abortion Statistics, England and Wales: 2002*, Bulletin 2002/2003

2.2 Key challenges

The principal challenge within sexual health is for the issue to be normalised and established as a central feature of public health. It is vital that sufficient priority is afforded to sexual health in order to tackle the problems outlined above. We welcome the development of the Public Health White Paper and hope that it will serve as a significant step forward in prioritising sexual health and taking a holistic approach to improving the nation's sexual health.

The IAG believes that there are two key areas which must be addressed in order to improve sexual health overall:

- **Prevention**: world-class services will only work if they are supported by world-class prevention work – starting with education. It is essential that there is an integrated approach to prevention which covers comprehensive sex and relationships education (SRE) in schools as well as national information campaigns for adults and hard-to-reach groups.
- **Delivery**: there must be commitment and action to deliver better services at the front line, in primary care and specialist services. The IAG supports a national programme for chlamydia screening, urges open access to GUM services, access for all to the full range of contraceptive methods, and improvements in abortion services. Standards for treatment must be set, and the training needs of the workforce identified and addressed.

3 Prioritisation: Sexual Health in Context

3.1 National prioritisation

The IAG strongly welcomed the Department of Health consultation on public health, '*Choosing Health?*', which concluded in June 2004 and included a significant component on sexual health. It is vitally important that sexual health is seen as an integral feature of public health, and that national leadership is provided on tackling the current problems in sexual health. The IAG was pleased to be able to contribute a robust submission to this consultation[3].

Following this consultation, we look forward to the forthcoming White Paper on Public Health. In particular, we are encouraged that the recently published 2005-2008 Planning and Priorities Framework (PPF) for the NHS stated that: "*The Public Health White Paper later this year will cover teenage pregnancy and will also set out comprehensive proposals for tackling sexually transmitted infections (STIs). The sexual health areas which will be particularly relevant for PCTs and their Local Authority partners to cover in their plans are: STI (and HIV) rates; holistic access times (covering both STI and reproductive health); and contraceptive and sexual health services provision*"[4]. The IAG is also pleased that the PPF acknowledges that the National Strategy for Sexual Health and HIV is equivalent to a National Service Framework (NSF) in importance, even though it is not explicitly described as such[5].

We welcome the fact that the joint Department of Health/Department for Education and Skills PSA target on reducing teenage pregnancy has been re-worded as follows: "*reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), **as part of a broader strategy to improve sexual health***". We believe it is wholly appropriate for there to be more explicit recognition of the holistic nature of sexual health problems and solutions, including teenage pregnancy.

However, the IAG is very disappointed that there were no new specific targets for sexual health included in the PPF. Given the competing priorities for funding and resources within PCTs, we believe that it is vital for there to be specific and measurable targets for sexual health services, and for PCTs to be performance managed against these. We have previously cited evidence[6] which shows that, without such targets, national prioritisation and strategy does not necessarily translate into action at a local level.

Recommendation 1

Sexual health should be explicitly prioritised within the NHS Planning and Priorities Framework, including the establishment of specific and measurable targets.

3.2 Prioritisation at local level

It is clear that until such time as sexual health is made a local priority for PCTs and performance managed by Strategic Health Authorities (SHAs), we will see a decline in service standards and the nation's sexual health. Sexual health and HIV should be included in all Local Delivery Plans and there should be an explicit role for Strategic Health Authorities in ensuring the implementation of this recommendation. This is currently not happening, and continuing failure to do so will result in the further decline of services.

The IAG welcomes the publication by the Department of Health of the Recommended Standards for NHS HIV Services[7] and the forthcoming Recommended Standards for Sexual Health Services[8]. We also welcome the Department of Health guidance on commissioning and health promotion[9] as extremely useful tools to support local commissioning and provision of services.

Recommendation 2

PCTs should make full use of all existing guidance and standards in the development of their sexual health and HIV services, and that PCTs use these to support their local monitoring of services with Strategic Health Authorities.

Recommendation 3

Following publication of the Public Health White Paper, the IAG looks forward to Strategic Health Authorities and PCTs setting their own local targets for sexual health. Services for sexual health must be included in Local Delivery Plans and adequately performance managed. Strategic Health Authorities must undertake this monitoring and performance management role.

[3] Available on the Sexual Health pages of the Department of Health website at www.dh.gov.uk
[4] *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08*, Department of Health, 2004
[5] ibid, p8
[6] Independent Advisory Group on Sexual Health and HIV, *Response to the Health Select Committee Report on Sexual Health*, January 2004, p8

The IAG recognises that many areas of public health – including teenage pregnancy – have benefited from a regional infrastructure, reporting to the Director of Public Health in each of the nine government office regions, which has helped to strengthen and support work at a regional level. The IAG believes that such an infrastructure would be invaluable in the co-ordination of responses to sexual health problems, particularly as these cross geographical boundaries and are often best served by a joined-up approach.

Recommendation 4

The IAG would like to see the development of a network of new regional co-ordinators for sexual health, to support and strengthen the work being done at PCT level.

[7] MedFASH 2003
[8] MedFASH, due spring 2005
[9] Effective Commissioning of Sexual Health and HIV Services, January 2003, Department of Health

4 Prevention: building for the future

The IAG believes that the only way to improve people's sexual health and sustain good sexual health in the long term is by:

- ensuring that people are well informed and able to make choices about sex and relationships, how to stay healthy, how to resist pressure and say "no" to unwanted sex, how to protect themselves from sexually transmitted infections, and how to control fertility and avoid unwanted pregnancy;
- ensuring that people are able to access appropriate support, advice and services across the broad range of sexual health issues, at times and in an environment which meet their particular needs.

4.1 Sex and Relationships Education (SRE)

4.1.1 The importance of comprehensive SRE in schools

Research evidence strongly demonstrates the protective effectiveness of comprehensive and early SRE in empowering young people and encouraging them to have sex later and to use contraception when they do so. The Ofsted Report (2002) on effective SRE stresses the importance of such comprehensive approaches.

SRE should deal with issues of emotional development and self-esteem, it should enable young people to gain the skills to make informed, healthy choices about relationships and to be able to resist pressure to have sex, and it should ensure that issues of sexuality and different sexual choices are covered.

SRE should also link into bullying work and anti-bullying policies in schools, with particular reference to dealing with and stopping homophobic bullying which is widespread and can lead to depression, school phobia and ultimately suicide. Good Personal Social and Health Education (PSHE), within which SRE fits, develops young people's broader life skills, which is particularly important in the context of interrelated issues such as the use of alcohol and other drugs and their influence on risk-taking behaviours, including unsafe sexual activity.

It is worth noting here that there is clear evidence that abstinence-only education is ineffective. Abstinence-only approaches do not equip young people adequately to negotiate positive relationships – evidence shows that 88% of those who take an abstinence pledge ultimately break this pledge, and are subsequently at higher risk of STIs and unwanted pregnancy because they have often had little or no information about contraception and safer sex.

Recommendation 5

The only way to develop a society where the importance of good sexual health is understood and positive behaviours in relation to sex and relationships are seen as the norm, and to achieve sustainable, long-term improvements to the nation's sexual health, is by ensuring that all young people receive high quality sex and relationships education as their entitlement. The PSHE framework – including comprehensive SRE – must be included as a statutory part of the National Curriculum at all Key Stages.

4.1.2 SRE outside the school environment

Making SRE a compulsory component of the National Curriculum is a vital means of ensuring that the majority of children and young people have access to sex and relationships education. However, there will always be children and young people who – for whatever reason – are outside the school environment for some or all of their schooling.

In order to cater for the needs of this group, local strategies should be developed to ensure that the equivalent of the compulsory PSHE/SRE curriculum

is provided to young people who are excluded from school or who are taught outside the state education system. We also believe that SRE should be offered in informal youth settings, through voluntary and statutory youth services, in FE provision, through Youth Offending Institutions, CAMHS teams and Connexions.

The Department of Health should continue to implement and expand its Training Action Plan to support the implementation of both the Sexual Health/HIV and the Teenage Pregnancy Strategies, with a particular emphasis on training for those who offer formal and informal SRE to children and young people.

4.1.3 Increasing aspirations and raising self-esteem

A review of the literature on the link between teenage pregnancy and self esteem concluded that the risk of teenage motherhood is raised – possibly by up to 50% – among teenage girls with lower self-esteem than their peers[10].

Youth development programmes can be extremely effective in raising self-esteem and reviews agree that there is evidence to support the effectiveness of a number of different models which combine some or all of the following: self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports and arts activities, and SRE[11]. Information and services are not in themselves enough to promote the sexual health and well-being of young people.

They must also be enabled to develop a sense of self worth which will enable them not to take self-destructive risks, to resist unhelpful peer pressure or harassment and to build satisfying and respectful relationships.

Unless young people feel that they themselves are worth good treatment and loving relationships, they will not be in a position to assert their right to these, and return them. Addressing positive self-esteem issues will be crucial to this. The importance of self-esteem building programmes should therefore be taken into account in the development of SRE programmes and sexual health services for young people.

4.1.4 Training for professionals

Children and young people are entitled to comprehensive SRE which is delivered by trained professionals. Teachers who do not have relevant training can lack skills and confidence, and this can have a negative impact on the quality of the education delivered. All professionals involved in PSHE and SRE should have appropriate training and support to enable them to deliver young people's entitlement to SRE.

Recommendation 6

In support of high quality SRE, the current PSHE teacher certification scheme, part of the National Healthy School Standard (NHSS), should be extended nationally so that each school has at least one appropriately trained teacher able to deliver PSHE/SRE across the school.

4.1.5 Peer education

Peer education can be a valuable tool in delivering effective SRE to young people. However, it is important that all who deliver SRE – including any young people involved in peer education – are fully trained and supported in their delivery of it, and that SRE programmes are monitored and evaluated to ensure that they meet young people's needs.

The IAG believes that a set of quality standards for peer education in SRE should be developed. All those developing peer education projects in formal and informal educational settings should be required to work to these guidelines to safeguard young people, facilitators, and the integrity of this delicate but undeniably effective work.

[10] Emler, N. (2001) *Self-esteem: the costs and causes of low self-worth*. York: Joseph Rowntree Foundation

[11] Swann, C. Bowe, K. McCormicK, G. and Kosim, M. (2003) *Evidence-based briefing paper on teenage pregnancy and parenthood*. Health Development Agency

4.1.6 Work with parents and carers

The IAG recognises that parents can play a crucial role in giving information and advice to children about sex and relationships. Parents have been called 'the first and most enduring sex educators in our children's lives'[12], and research shows that children and young people from families in which sex and relationships are openly discussed are more likely to delay the age at which they first have sex[13], have fewer partners, and use contraception when they do have sex . However, parents and carers need support in order to be able to speak to their children about sex and relationships.

Programmes with parents/carers are an excellent way of developing parents' abilities to speak with their children about relationships and sex, in itself a determinant of young people being able to make healthy and informed decisions. Young people who can discuss these issues with their parents report delaying first sex and more consistent condom/contraception use.

4.2 Young people's services

4.2.1 Confidentiality

The IAG strongly welcomes the Department of Health revised guidance on the provision of sexual health advice and treatment to under-16s[14], which clarifies and reinforces current practice amongst health professionals. Young people who need contraception and/or testing for STIs must have easy access to services, and need assurance of confidentiality in order to access these services. It is therefore vitally important that confidentiality is well publicised and understood.

Health care professionals providing services to young people should also have training and support in implementing the most up-to-date guidelines on confidentiality and child protection.

Recommendation 7

PCTs must continue to provide confidential sexual health services for young people under 16. We recommend that all PCTs, LEAs and Connexions services should publicise local sexual health services – and their confidentiality – widely to young people.

4.2.2 School-based health services

School-based health services can make an important contribution to the sexual health and wellbeing of young people. These services can be integrated with SRE provision within a school, thereby enabling young people to access a comprehensive range of information, advice and services within a familiar setting and at times convenient to them.

In addition, school nurses can be an essential focal point for provision of advice and support to pupils. Along with the PSHE coordinator, they can facilitate visits from their colleagues in the community and work with them to provide health promotion and improve young people's access to sexual health services. School nurses can also provide a valuable service within schools, particularly in terms of providing emergency hormonal contraception and advising on other forms of contraception.

School based health services are currently sporadic depending on local funding. Models of good practice

[12] Alexander, T, *Empowering parents: Families as the foundation of a learning society*, National Children's Bureau, 1997

[13] Ingham, R., *The development of an integrated model of sexual conduct amongst young people*, University of Southampton, 1997; and Barnett, B, Gender norms affect adolescents, Network 17:3, 1997

[14] *Best Practice Guidance for Doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*, Department of Health, 2004

should be available to all schools to develop services that suit their population. PCTs should support their health professionals who work in schools and provide funding for these services.

4.3 Prevention in the general population

It is important that prevention work addresses the needs of all people. While it is crucial that comprehensive SRE begins at school age for children and young people, older people must also have access to information, education and advice services to meet their sexual health needs. At the same time we need to remember that in respect of issues like HIV, gay men, who have been the group most affected, still need the support of effective prevention campaigns. Not only in support of new generations of gay men as they become sexually active but also in recognition of the new and changing need for advice amongst gay men living with HIV as a direct benefit of the new treatments available.

4.3.1 Public health campaigns

There is a lack of specific funding for sexual health promotion, particularly at a national level. The IAG strongly argues that more work needs to be carried out 'upstream' in prevention, in order to reduce costs of work 'downstream' in treatment and care.

The national campaign, the Sex Lottery, targets young people specifically and informs them about the risks of STIs and how to access services and further information, as well as free confidential advice. This campaign has proven its effectiveness in communicating with this audience and continues to sustain high recognition levels amongst young people. It is therefore very important that the Sex Lottery campaign is further developed, continued and expanded.

In order to reach other audiences, there should also be developed further national information and prevention campaigns aimed at different target groups. Prevention work such as information campaigns and local promotions must be accessible to all. People of all ages, speakers of many different languages and cultural backgrounds, and people with a range of ability are all target audiences for information on sexual health.

Sexual healthcare providers around the country work hard to provide services specifically targeted at their local communities. Each community has unique needs – and PCTs are continually encouraged to engage with their communities to assess service provision and barriers to those services. Hard-to-reach groups must be engaged to ensure prevention is rigorous and effective.

Recommendation 8

It is vitally important that the Sex Lottery campaign should continue, and should be complemented and enhanced by further national information campaigns for older age groups and specific target audiences.

4.4 Prevention – the burden of cost

The IAG is extremely supportive of the fact that contraception is available free to all on the NHS. Contraception is the ultimate preventive tool in reproductive sexual health, and it is estimated that it currently saves the NHS over £2.5 billion per year. However, the cost of over-the-counter contraceptives – including condoms and emergency hormonal contraception – is high and prohibitively expensive for many people.

In particular, the cost of condoms (which can act to prevent both unplanned pregnancy and STIs) is much higher in the UK than in other European countries, and this high cost can be a disincentive to consistent use in certain target groups including young people and those on low incomes. The IAG is keen to support improved condom use, and recognises that people must have the choice either to access condoms free of charge through the NHS or to buy them over the counter.

Recommendation 9

We support an expansion in the availability of free condoms through the NHS, including an increase in the type and number of outlets through which these can be accessed, as well as the abolition of VAT on all over the counter contraceptives in order to promote consistent use.

4.5 HIV Prevention

The IAG believes there is a clear need for improved HIV prevention work, including better co-ordination between national and local work, plus a specific need to improve work with populations at heightened risk and with young people across the board. It is important to focus on nationally co-ordinated prevention programmes and campaigns for each of the groups at greatest HIV risk, based on the Department of Health funded Community HIV & AIDS Prevention Strategy (CHAPS) model, with enhanced resources and clear links to local work. The IAG also recognises the innovative work for African communities commissioned by the Department of Health from the African HIV Policy Network. Establishing national standards for HIV prevention work and a national capacity building programme for organisations delivering HIV prevention work at a local level, would ensure or assist in ensuring quality and consistency.

Recommendation 10

The increase year on year of HIV reports cannot just be related to people seeking to know their HIV status as a result of improved treatments. There is a need to have effective and sustained prevention campaigns for those groups most at risk. These campaigns should be based on the experiences of the CHAPS project which are linked and complemented by locally led initiatives that share the aims of to reaching groups at risk and the new generations of young people who have little or no experience and knowledge of HIV and AIDS.

Local action is also essential. We recommend local HIV prevention programmes in all areas of significant HIV and STI prevalence, funded and initiated by PCTs and integrated throughout clinical and community settings. These should include clear health aims, should work across networks and should include some or most of the following services:

- the availability of printed information about HIV in all appropriate NHS services and in all appropriate community settings;
- the provision of 'face to face' services in community settings and the use of peer based education work with communities with highest prevalence of HIV;
- use of electronic information services and text messaging as a means of delivering prevention messages;
- collaborative programmes involving voluntary/community services delivered within clinical sexual health service settings, including counselling and peer support.

Also on a local level, expanded community and clinic-based work with people living with HIV from point of diagnosis onwards is a must. This work will support people in reducing onward transmission of HIV, and will enable improved co-ordination of sexual health services for people with HIV.

We believe primary care services should consider sexual health within general health checks. In order to achieve a more holistic HIV/AIDS service primary care services should make condoms and lubricant more widely available, in particular to gay men and BME communities, and establish sensitive programmes of HIV prevention work with those outside the NHS and statutory services. A holistic service should also include clinical preventive interventions including vaccination programmes for Hepatitis A and B and HIV post exposure prophylaxis, targeted at those people at greatest risk and using British Association for Sexual Health and HIV (BASHH) guidelines.

Recommendation 11

Nationally co-ordinated and targeted HIV prevention programmes for gay men and African communities should be continued and expanded. PCTs should ensure that local HIV prevention programmes build on and reinforce these campaigns.

4.6 The National Chlamydia Screening Programme

The IAG fully supports the national chlamydia screening programme, and we believe that there should be an explicit aim for this programme to reach national rollout within the next two years. With the successful initiation of the 10-site roll out, much of the infrastructure required for central coordination and implementation is now in place, and every effort should be made to expedite roll-out across England.

Chlamydia screening needs an innovative approach and must be locally driven – linked to local chlamydia prevention and control efforts – and evaluated. Models of good practice and innovation should be disseminated widely. Initial 'pump-priming' funds should not be seen as the only means for starting chlamydia screening at local NHS sites. PCTs do not need to wait for the roll-out of the national programme and should be encouraged to commence screening as soon as possible.

Finally, suboptimal tests must be replaced – in a phased nationally rolled out programme – by nucleic acid amplification (NAATs), technology in order to ensure more accurate testing.

Recommendation 12

The national chlamydia screening programme should be expedited and fully rolled out within the next two years. Chlamydia testing in all laboratories should be performed using NAATs technology.

5 Delivery: how can we deliver better services?

5.1 General Practice and the GMS Contract

To anchor sexual health as a mainstream public health issue it must also be centred in essential health services, including general practice. The vision behind the new GMS contract is that it will act as a lever to improve the quality of all services provided by general practitioners. In terms of sexual health, there is the opportunity to push, at a local level, for an expansion of services which eventually may lead to a redesign of the provision of sexual health services.

The new contract has three categories, or levels of service, that general practitioners will be providing: essential, additional and enhanced. In addition, the contract will reward practices for the quality of services it provides through the Quality and Outcomes Framework (QOF). The new contract guarantees an increased investment in general practice of 33 percent over the next three years. The contract will be kept under review for the first year of operation, and will be reviewed again after a further two years. There is scope for change, and the potential for the range of enhanced sexual services at both a national and local level to be increased.

However, the IAG is concerned that the contract, as it stands, does not make more explicit reference to sexual health. We believe that not only should sexual health be included more comprehensively in all future revisions of the contract, but also that PCTs need to take a lead in setting standards and managing the performance of their general practices in all areas of sexual health.

5.1.1 Quality Outcomes Framework (QOF)

A key purpose of the contract is to improve the quality of primary care, and two-thirds of that investment will be available through the QOF. The QOF comprises 1050 points against quality indicators. Each point is worth an average of £75 per practice in year one, increasing to an average of £120 in year two.

The IAG is extremely disappointed, in relation to sexual health, that services can only achieve one quality point for having a written policy on emergency contraception, and one quality point for having a written policy on pre-conceptual care. This has the potential to be a serious disincentive to general practices to improve the quality of their sexual healthcare, and in particular, the contraceptive advice and treatment they provide.

Recommendation 13

We strongly recommend that further quality points for sexual health are included as a priority in future development of the Quality and Outcomes Framework.

5.1.2 Contraception

Approximately 75% to 80% of contraceptive care is currently provided through general practice. The new GMS contract requires general practices which provide contraception as an additional service to advise on the full range of contraceptive methods, and we welcome this development. However, as outlined above, there are no quality points explicitly linked to the provision of advice on the full range of methods, and there is also no training or performance management requirement attached to this provision.

The IAG urges that general practices which do sign up to providing contraceptive services as an additional service should take seriously the requirement to advise on all methods, and that PCTs should monitor their performance in this area.

5.1.3 Abortion Referral

Research shows that some GPs and health professionals do not provide information about their position on abortion and delay a woman's access to abortion services. Some women are reluctant to seek care when faced with an unwanted pregnancy. PCTs should provide access to non-judgemental and non-directive services for initial referral for abortion, or allow self-referral for initial assessment by abortion providers. Lack of availability of on the spot free pregnancy testing in Primary Care can lead to delayed diagnosis of pregnancy and reduce the options in the choice of method of provision abortion – early medical or surgical.

Recommendation 14

The IAG recommends the availability of on the spot free pregnancy testing to facilitate an early diagnosis of pregnancy

5.1.4 STI testing and treatment

The National Strategy for Sexual Health and HIV envisages an increased role for primary care practitioners in STI management. However, little priority has been given to this within the new GMS contract and there has been little or no consideration of the essential role, and its manpower implications, of GUM specialists for training and assessing the competencies of primary care practitioners. Unless this issue is addressed and there is the requisite priority and funding for STI screening in GP contracts, it is unlikely that primary care will achieve its full potential in support of the specialist services.

5.2 GUM Services

In its first year, the IAG has looked at the delivery of GUM services and how these services are being impacted by the rise in sexual health problems.

5.2.1 Access

Waiting times for urgent appointments for GUM services have continued to deteriorate during the past year.

Patients with a potential sexually transmitted infection should be seen as quickly as possible to limit complications and further transmission of infection as well as enabling more rapid contact of sexual partners.

This expedient public health approach underlines the policy of an open access self-referral service. A survey carried out by the Association of Genitourinary Medicine in 2002 reported that male and female patients wait on average 11 and 12 days respectively to be seen in a clinic, but that this waiting time can be anything up to six weeks. Such delays work against good control of STIs. We reinforce the aim of the National Strategy that anyone wishing to access these services should be able to do so on the day or the day after presentation to a clinic.

The Department of Health has stated that it wishes to develop a GUM waiting time performance indicator and to this end has commissioned the Health Protection Agency (HPA) to carry out a further waiting time survey. Preliminary data from the pilot survey carried out in February 2004 indicates that 51% of patients wait more than 48 hours to be seen and that access is worse outside London.

The Department of Health has already set a 48-hour target for primary care and GUM should also be viewed as a primary care and public health priority service in view of the fact that patients, in most instances, refer themselves and have urgent transmissible problems.

Recommendation 15

While open access for all is our ultimate aim, it is essential that a 48-hour target for access to specialist GUM services is set by the Department of Health and that this should be a target upon which PCTs are measured and assessed.

5.2.2 Funding and Infrastructure

The GUM estate needs to be upgraded throughout England. We have highlighted the inadequacy of many GUM clinics, which were incapable of meeting the rising demands being placed upon them. In 2003-4, a capital sum of £15 million has been allocated to upgrade clinic facilities. This is only a fraction of the £200 million recommended as being necessary in a specialist society report in 2002 and given as evidence to the Select Committee.

The Department of Health has commissioned the Medical Foundation for Sexual Health (MedFASH) to carry out a GUM service review to look at some of the issues of estate, facilities and service provision. We welcome the GUM service review and await its findings.

The IAG is extremely concerned that targeted allocations of Government funding for improving access have failed to reach many GUM clinics. A survey carried out by the British Association for Sexual Health and HIV (BASHH) found that targeted funding in 2003-04 to improve access to GUM clinics had not reached the clinics. It found that in many cases the funding was retained all or in part by PCTs and had not been used for its intended purpose.

Recommendation 16

Additional resources are required to ensure that all clinics have the necessary facilities and space requirements to meet current and anticipated patient needs. It is important that the government provides continued support and investment in manpower and estate in order for GUM clinics to fulfil this role.

Recommendation 17

A full audit of targeted GUM funding should be performed. Specifically, the government must ensure that all of the recurrent funding targeted for GUM clinics reaches its intended recipients and is used to improve access to these services.

5.2.3 Staffing

The need for consultant expansion in GUM has been recognised by a further increase in the numbers of specialist registrars in training. However, this has not been translated into an increase in consultant numbers. There are particular delays in the development of specific areas and there are still many consultants working single-handedly. Moreover, many new appointees are choosing to work part-time, effectively reducing the whole time equivalent increase in consultant numbers.

5.3 Contraceptive Services

Access to and use of contraception is fundamental to physical and mental health for the majority of those who are sexually active and their families. It is one of the basics of preventive health care. Attitudes to sex and sexual behaviour influence the perception and use of contraception. Social deprivation and exclusion result in reduced access to contraception and the effectiveness of methods chosen. It is women who must use all the reversible contraceptive methods except condoms, and so women-friendly services are essential.

The dual provision of contraceptive services from networks of community contraceptive clinics and from general practice is in recognition of the importance to the public health of the appropriate use of contraception by all who need it. There are complex wider determinants of use of contraception than simply the availability of services, but good services are necessary. The development of integrated and effective local community clinic and primary care contraceptive provision with locally established care pathways are needed to ensure access to all methods.

Providing choice of services is necessary to improve uptake of contraception. Community clinic services are of particular use for:

- those not registered with a local GP;
- those whose GPs do not offer contraception or only offer a limited range of contraceptive methods;
- those who for personal or cultural reasons will not consult their GP;
- those with particular difficulties in their use of contraception.

There are 2.6 million attendances at community contraceptive clinics in England and Wales each year. Community clinic services are organised in networks, providing sessions from local sites without catchment restriction. Services are generally available to all on an open access self-referring basis. These clinic networks vary in size from less than 1,000 to over 70,000 attendances each year and tend to be concentrated in areas with higher deprivation, but the range, quality and accessibility of service provision across England does not seem to reflect the pattern of need. Many of the clinic sessions take place in premises that are un-modernised and without facilities for optimal service provision.

Community contraception sessions also have an important part to play in the chlamydia screening programme. There were 63,000 women under 25 years of age who had consultations at community contraception clinics last year. Care should be taken to support the community contraceptive services, or a significant opportunity to implement chlamydia

screening will be lost. The roll-out of the chlamydia screening programme should also provide opportunities for community contraceptive clinics to forge working links and care pathways with local GUM services.

5.3.1 Access

Information for local people about the services available for them is generally poor.

Contraceptive services are not adequately advertised. Active promotion of contraceptive methods and their availability is necessary to overcome the hurdles of taboo and ignorance to which we are heirs. There are currently no budgets for such service advertising. Once in contact with services people need information to help them choose and use methods effectively. Clear and pertinent information on choice and use of contraceptive methods and on STIs should be available from all providers, for example the Department of Health funded leaflets produced by fpa as part of Sexual Health Direct, on contraception, abortion and STIs, should be used by professional in sexual health to complement the advice they give in consultations.

Recommendation 18

Performance management of PCTs' local commissioning groups and Local Delivery Plans should include access to contraception. Local commissioners must identify current patterns of provision both from primary care and community clinics and local needs for contraceptive services.

5.3.2 Funding

Evidence shows that contraceptive services have been consistently deprioritised at a commissioning level. A 2003 review of English Strategic Health Authorities' Local Delivery Plans showed that none of the 24 surveyed mentioned contraceptive services[15]. The 2003 Report on Sexual Health from the House of Commons Health Select Committee commented that "*we have received compelling accounts of disinvestment in these vital services, and the fact that contraceptive services are not even included within the Strategy's*[16] *five aims is further evidence of this creeping deprioritisation*"[17].

More focus and impetus to improve contraceptive services across all providers is urgently necessary to ensure that Primary Care Trusts, which now both purchase and provide both primary care and community clinic contraception, are supported in improving the availability, quality and range of services for local people.

Recommendation 19

PCTs and Strategic Health Authorities must ensure that contraceptive services are fully funded and resourced, and should also undertake comprehensive data collection to evaluate and monitor service provision.

5.3.3 Staffing

Helping women and men make a contraceptive choice in which they can feel confident requires professionals to have up to date and objective information on the choices that are available and can communicate well. All clinicians who advise on contraception need access to training, and this should be updated regularly to take into account new methods as they are developed.

Most family planning sessions are provided by part-time staff working to outdated terms and conditions of service. There is no established career path for those clinicians who are needed to provide service leadership. Training for both nurses and doctors is in a state of disorganisation and is patently inadequate to meet the needs of current service provision, let alone any required new developments. All contraceptive services have been experiencing increasing difficulties in staff recruitment in recent years; this has now reached crisis levels, putting great strain on existing staff and forcing reduction in services offered. This shortage of staff also threatens the development of nurse prescribing and nurse-led services

Action is necessary to review and revise training available for clinicians offering contraceptive care. The terms and conditions of employment and career structures in community contraceptive clinics should also be addressed.

Recommendation 20

The Department of Health should review the staffing situation and take steps to ensure that adequate staff are available.

[15] *Review of Strategic Health Authority Local Delivery Plans*, Brook, fpa, Terrence Higgins Trust, August 2003
[16] National Strategy for Sexual Health and HIV, 2001
[17] House of Commons Health Committee, 2003, as above

5.4 Abortion Services

NHS abortion services have considerably improved in the past few years and many further changes are taking place now. However, the All-Party Parliamentary Pro-Choice & Sexual Health Group reported, this year, that despite improvements some PCTs are still operating bad practices such as slow referral systems, inadequate provision and restrictive policies. The Group found there is a real need to instigate changes to meet national standards.

Recommendation 21

All PCTs should aim to commission adequate services to cover the full demand for abortion among their local population. All PCTs should have written protocols, service specifications or guidelines on good practice to cover all aspects of abortion services.

5.4.1 Access and waiting times

Most PCTs are willing and able to reach the minimum national standard waiting time for abortion of three weeks. Almost one third of abortion services treat all abortion patients in 14 days or less. The time has come to consider reducing the national standard waiting time at least to two weeks, working towards an ideal standard of less than one week. Although most PCTs could achieve this, more than 25% still have an unacceptable waiting time of more than three weeks for women requesting abortion.

It is important that sexual health services can be accessed in locations within the community and close to where people live. In terms of abortion services, there is further progress to be made in terms of extending access. Many women face long and unacceptable waits for an abortion to be carried out in a hospital. We believe that early medical and surgical abortions could be carried out in community settings such as family planning clinics and general practices, thereby making use of existing settings and enabling greater access and choice for women.

In 2003, 80% of abortions were funded by the NHS – however, although in some areas almost all abortions are NHS-funded, in others less than two-thirds are. All women who want to do so should be able to access abortion services funded by the NHS.

Recommendation 22

All PCTs should provide most abortions for local women in considerably less than the minimum national standard of three weeks from first appointment to abortion procedure. As a minimum, we recommend that at least 90% of abortions should be paid for by the NHS.

5.4.2 Staffing

In a small minority of areas, difficulties in commissioning abortion services from local NHS Trusts persist, despite national guidelines and targets. This problem should be tackled by PCTs. Steps should be taken to increase availability of abortions at local hospitals despite the reluctance of some gynaecology specialists to undertake this work, or PCTs should commission terminations from non-NHS providers on an agency basis.

Enhancing training in abortions is crucial to counter the national decline in abortion services by hospital based gynaecologists. There is also a need to widen the pool of professionals able to perform abortions, and to therefore extend training to medical staff such as GPs, family planning consultants, and – within the provisions of the law – nurses. This would help to compensate for the lack of suitably trained gynaecologists and would thereby speed up waiting times and improve access.

5.4.3 Early Abortion

With the emphasis moved from not just making abortions available from the NHS but also making them available quickly, so has the focus turned to the potential for improving availability of medical and early surgical abortions. As stated by the Commission for Health Improvement: 'The earlier in pregnancy an abortion is performed the lower the risk of complications… If women can access services before they are nine weeks pregnant, they can potentially have a choice of an early medical or surgical abortion – medical abortion avoids the need for anaesthesia'.

Medical abortion costs less, is less invasive, and is preferred by many women. If used more widely it would offer a greater level of choice to women, and could significantly speed up access to the process, thereby reducing waiting times. Similarly, abortion by local anaesthetic for surgical abortions offers benefits to women but usage is patchy and largely dependent on the personal preferences of the clinicians involved.

Recommendation 23

PCTs should ensure that women have access to early medical and surgical abortion.

5.5 HIV/AIDS Services

In the past year members from the IAG have looked specifically at the problem of support for HIV and AIDS within the broader provision of sexual health care.

5.5.1 Diagnosis

Although there has been a tremendous amount of good work done to combat HIV and AIDS, there is an urgent need to reduce the level of undiagnosed HIV within the UK. To achieve this we need to build upon current work with fresh approaches which make it easier to take an HIV test through better access to and simpler care protocols for HIV testing services and use of new diagnostic technologies.

Better local HIV diagnosis should include the establishment of a range of settings in which people can choose to test, and the hours at which they can get one, essentially taking HIV tests closer to the person. These should be directed to and accessible to communities at greatest HIV risk, and should be backed up by information campaigns encouraging people to have an HIV test. These services would sit within local HIV testing networks, with GUM services at the centre but including primary care and community service satellites to attract communities at heightened risk and offering "walk-in" same hour testing services

Another improvement would be to train primary care and other clinical and community based

staff to recognise potential indicators of HIV disease and to support consideration of testing. We also recommend the shift to an "opt out" approach to HIV testing in GUM clinics, similar to measures successfully undertaken to reduce antenatal HIV transmission

We also know faster is better and we should use new HIV testing technologies to improve diagnosis waiting times, including same day and one hour results services. We must also consider the legalisation of home and over the counter HIV testing kits to empower people to establish their own HIV status. These kits should meet relevant efficacy and quality standards. Such approaches should ensure rapid access to structured advice and support as well as to high quality information.

The IAG welcomes the pilot project the Department of Health is funding on HIV testing and syphilis screening for at risk groups in non-clinical settings. If successful this should help alleviate pressure on GUM services and help reduce undiagnosed cases.

Recommendation 24

Targeted campaigns highlighting the advantages of HIV testing should be implemented nationally and locally. In GUM clinics, HIV testing should be routinely offered and recommended to all patients and urgent consideration should be given to expanding HIV testing services in Primary Care and community settings.

5.5.2 Treatment & care

The UK has every right to be proud of the high quality of HIV treatment and care provided by specialist GUM and HIV Outpatient services.

World-class HIV treatment and care is provided by the NHS and this is enabling HIV survival rates and life expectancy to continue to grow. However, these services are coming under increasing pressure as a result of the growth in numbers of people living with HIV and the changing patterns of the epidemic in this country which is increasingly amongst families in ethnic communities with different needs and experiences of HIV as well as attitudes to their own or one of their families diagnosis.

To further develop local HIV treatment and care services a new approach is needed – one which reduces the level of primary care carried out in specialist hospital settings. Such approaches should include the development of community based GPs with specialist knowledge in the primary care of people with HIV and the establishment of HIV Out Patient Departments attached to GP services, where appropriate.

If we establish integrated health and social care services in each HIV treatment centre, we reduce the time spent by NHS specialists addressing the social care needs of people with HIV. This will require close joint working between the NHS, community organisations and local government, and increased recruitment and training of specialist HIV social workers, but will enable more efficient use of clinical resources, an improved patient experience through appropriate, specialised and sensitive services, and progress in tackling health inequality.

We can free up services by expanding self-management approaches for people living with HIV, including provision of information, online and telephone support as well as online access to clinical results as appropriate. Ultimately we need to move to a staged standard of care such that people with lower needs on stable treatment regimens might have less frequent medical follow up, enabling those in greater need to have access to more frequent medical input as required. Regular diagnostic tests would however continue to be necessary but could, for example, be undertaken at primary care sites or community organisations based closer to a person's home.

We should increase the use of nurse practitioners and nurse prescribers in the routine follow up and ongoing care of people with HIV. Innovative approaches such as home delivery services for routine HIV medication must be encouraged. Also essential is the establishment of a "safety net" service for people unable to access statutory support and NHS services, who nevertheless need care and treatment for both public health and individual health reasons.

Taken together, these ideas will create a service of which the NHS and the HIV voluntary sector can be proud. In their vision for 2008, the IAG sees a service which places people with HIV at the centre of decision making.

Recommendation 25

PCTs should explore establishing integrated health and social care services created through partnerships between HIV treatment centres, local government and community organisations.

Recommendation 26

The role of the AIDS Support Grant (ASG) as a dedicated funding source for local authority HIV services has become increasingly important in ensuring the development and integration of quality health and social care services. The ASG should be retained in order to support not only these planned changes but also the development of the skills necessary to appropriately meet the needs of the changing pattern of the HIV epidemic.

5.6 Delivering services for black and minority ethnic communities

The UK Black and Minority Ethnic (BME) population continues to disproportionately carry the burden of poor sexual health. The IAG observes that cultural differences have implications for the uptake of services, presentation of illness and patterns of disease.

5.6.1 Targeting services

Research has consistently demonstrated a disproportionate increase in risk of STIs in the UK BME population. HIV is on the increase amongst heterosexuals in the Caribbean and African communities. 60% of all new HIV diagnosis is acquired abroad in Africa. International travel to Africa, Thailand and the Caribbean accounts for increases in STIs. The number of diagnoses of HIV among Asian ethnic groups remain low, but vigilance is required in light of the growing HIV epidemic in the Asian subcontinent. Condom use does not appear to be commensurate with the risk of STIs, indicating the need for more effective prevention programmes.

It is therefore important for PCTs to profile their own BME communities in order to assess need. This will help establish an understanding of what religious and/or cultural beliefs and taboos which may affect sexual health are present in each community. PCTs

must then invest in active outreach promotion of sexual health services, working with organisations and leaders with positive images in BME communities. PCTs should work with existing community based organisations and media to communicate positive sexual health promotion information, benefits of early testing, screening and education.

Recommendation 27

PCTs should commission and provide sexual health services which are adequately tailored to meet the needs of ethnic minority groups. Recognition of cultural need and language barriers with widespread use of link workers and interpreting services is vital. PCTs should invest in training for frontline staff in provision of culturally sensitive services, and postgraduate medical education training boards should include teaching and guidance on sexual health including ethnic minority healthcare issues in the medical school curriculum.

5.7 One-Stop Shops

One-stop shops have long been the buzzword in sexual health as in one visit patients can be advised on their contraceptive needs as well as receiving testing, support, counselling and treatment for STIs.

The National Sexual Health and HIV Strategy and the Teenage Pregnancy Strategy both recommend a move towards more comprehensive and integrated services, but evidence is required to fully assess the benefit of this approach. For the first time, a joint team from University College London and Bristol University is studying the potential benefits of one-stop shops by evaluating the impact of three established services – in Birmingham, Morecambe and Enfield – compared to six 'traditional' services in the area. The study is designed to test the following hypotheses:

- The level of care in one-stop shops model is more integrated than the level of care provided in traditional models of sexual health provision;
- One-stop shop models of sexual health provision are more effective than the traditional models in both identifying and reducing poor reproductive and sexual health outcomes;
- One-stop shop models are more acceptable to the local community than less integrated models, and are better linked to health, education, social and voluntary services than more traditional services;
- Staff in one-stop shop services are more appropriately trained than other services;
- Economic efficiency will be greater following a move from traditional services to traditional services plus one-stop shops.

The three model services studied cover a dedicated young people's integrated genito-urinary and contraceptive service, a specialist mainstream service to meet the needs of all age groups, and a specialist primary care led service. This is a three year studying to be completed in 2006. The results will be widely published in peer review journals. The results will be widely circulated, and available on the sexual health pages of the Department of Health website.

The IAG welcomes this evaluation study, and looks forward to the results of this and further research in order to develop and make best use of integrated services where these are appropriate and effective.

6 Research and Epidemiology: Getting a clearer picture

6.1 The current picture

Sexual health has consistently failed to attract attention and significant investment for research. Whilst the Department of Health/MRC has allocated £1M per year for research there is still a real weakness in the epidemiology of sexual health with little co-ordinated data collection. The Department of Health is working with the HPA and others to develop a common data set to support clinical practice and facilitate surveillance and monitoring of the sexual health strategy. It will set the framework for service provision as recorded by a single harmonised data collection system across Primary Care, Family Planning and GUM.

Surveillance from primary care settings should build upon existing primary care monitoring systems, such as the GP Research Database (GPRD). However, the complexity and inconsistency of coding in these systems may not make this the best option for routine monitoring.

New studies examining the feasibility of combining GUM, laboratory and primary care data sources are now being undertaken, and these should help inform future comprehensive surveillance strategies.

Finally, opportunities for improving data collection across clinic sites may become available with the National Programme for IT which is responsible for implementing the £6 billion programme of IT investment in the NHS whilst ensuring that new investment is carried out using common standards and compatible systems.

6.1.1 STI/HIV data collection

GUM STI/HIV surveillance data focus entirely upon the specialist sexual health services and there is a need to improve data collection from other sources.

The UK is unique in having dedicated services for the diagnosis and treatment of STIs, and in England, quarterly statistical returns (KC60) from GUM clinics form the basis of national STI surveillance. KC60 collects aggregate information on episodes seen in GUM clinics. Although useful for monitoring workload and trends at clinic level, the KC60 provides little information for planning at the community level. This has become especially important with the National Strategy for Sexual Health and HIV's plan to increase the current level of STI diagnosis and care being provided by general practice and other primary care sites.

A number of regions in England already operate, or are piloting, enhanced electronic surveillance programmes for STIs based on datasets obtained from GUM clinics which collect disaggregate, anonymised and individual patient data. These programmes have highlighted some of the practical issues related to the implementation of these systems. Pilots for a national collection of enhanced surveillance data from GUM clinics (ProgrESS II) are being undertaken by the HPA CDSC with planned completion scheduled for March 2005.

6.1.2 Contraceptive data collection

KT31 collects annual statistical returns for contraception from community clinics, but provides little information for planning at community level, as it does not include primary care contraception returns. More robust data would enable national and regional planners to identify problems quickly and move resources to address them.

There are no co-ordinated plans to improve the quality of information from community contraceptive clinics, once the data-set is ready. The investment in IT which this will necessitate has not yet been identified.

6.2 Future Approaches to Research

6.2.1 Research Gaps

Few applications for social, behavioural, health services or clinical interventions have been submitted to the MRC, and although the descriptive studies supported

have the potential to inform interventions, this has not been the primary basis of these applications. Similarly, despite identifying diagnostic and technological innovation as key areas in which the Sexual Health and HIV Research Strategy Committee (SHHRSC) would like to see proposals, few have been submitted.

It is a more difficult task to identify other gaps in research, as little is known about the range, type and quality of studies funded under other forms of support. This leads us to the issues of mapping and coordination.

6.2.2 Mapping and Coordination

Although the MRC SHHRSC provides one means by which the Department of Health can achieve its sexual health and HIV-related research goals, there are a number of sources of research funds for sexual health research in the UK. Whilst undoubtedly generating a wide range of studies, this also results in duplication and production of outputs of variable quality and value.

There is an argument for bringing together the main funders of sexual health research in the UK, both to identify strengths and weaknesses, but also to seek a wide range of views and possibly consensus as to the direction in which future research effort could be directed.

Recommendation 28

The Department of Health needs to conduct a mapping exercise to determine the range and quality of sexual health and HIV research in the UK, and whether the current division of labour with regard to funding is appropriate, with a view to increasing the resources available to what has been a neglected area of research support.

6.2.3 Funding

Apart from the £1 million annual allocation to the MRC to support sexual health research, the Department of Health makes additional investments according to policy need. For example, the research undertaken in Portsmouth and the Wirral to determine the feasibility and acceptability of screening in general practice for chlamydia trachomatis; the evaluation of the teenage pregnancy strategy; studies of one-stop shops for young people's sexual health. All have been given support separately from and in addition to the allocation to the MRC, and the MRC has itself supported sexual health research separately from the Department of Health allocation.

The total money spent on sexual health research, including that deriving from sources other than the Department of Health and the MRC, should be determined as part of the mapping exercise suggested above. On the basis of such a review, we would be in a position to determine the appropriateness of the current level of investment.

Research as an area of current and future investment was not addressed in any detail in ether the National Strategy for Sexual health and HIV, nor in the recent Health Select Committee report. This warrants immediate and urgent review.

Recommendation 29

The Department of Health and MRC should work together with researchers and grant funding bodies to identify means by which more rapid progress can be achieved in supporting topics in which there is currently a dearth of submissions, notably the development and testing of interventions and diagnostic and technological innovation.

Annex I Recommendations

Prioritisation: Sexual Health in Context

1. The IAG would like to see sexual health explicitly prioritised within the NHS Planning and Priorities Framework, including the establishment of specific and measurable targets.

2. The IAG recommends that PCTs should make full use of all existing guidance and standards in the development of their sexual health and HIV services, and that PCTs use these to support their local monitoring of services with Strategic Health Authorities.

3. Following publication of the Public Health White Paper, the IAG looks forward to Strategic Health Authorities and PCTs setting their own local targets for sexual health. Services for sexual health must be included in Local Delivery Plans and adequately performance managed. Strategic Health Authorities must undertake this monitoring and performance management role.

4. The IAG would like to see the development of a network of new regional co-ordinators for sexual health, to support and strengthen the work being done at PCT level.

Prevention: Building for the Future

5. The only way to develop a society where the importance of good sexual health is understood and positive behaviours in relation to sex and relationships are seen as the norm, and to achieve sustainable, long-term improvements to the nation's sexual health, is by ensuring that all young people receive high quality sex and relationships education as their entitlement. The PSHE framework – including comprehensive SRE – must be included as a statutory part of the National Curriculum at all Key Stages.

6. In support of high quality SRE, the current PSHE teacher certification scheme, part of the National Healthy Schools Standard (NHSS), should be extended nationally so that each school has at least one appropriately trained teacher able to deliver PSHE/SRE across the school.

7. PCTs must continue to support confidential sexual health services for young people under 16. We recommend that all PCTs, LEAs and Connexions services should publicise local sexual health services – and their confidentiality – widely to young people.

8. It is vitally important that the Sex Lottery should continue, and should be complemented and enhanced by further national information campaigns for older age groups and specific target audiences.

9. We support an expansion in the availability of free condoms through the NHS, including an increase in the type and number of outlets through which these can be accessed, as well as the abolition of VAT on all over the counter contraceptives in order to promote consistent use.

10. The increase year on year of HIV reports cannot just be related to people seeking to know their HIV status as a result of improved treatments. There is a need to have effective and sustained prevention campaigns for those groups most at risk. These campaigns should be based on the experiences of the CHAPS project which are linked and complemented by locally led initiatives that share the aims of reaching groups at risk and the new generations of young people who have little or no experience and knowledge of HIV and AIDS.

11. Nationally co-ordinated and targeted HIV prevention programmes for gay men and African communities should be continued and expanded. PCTs should ensure that local HIV prevention programmes build on and reinforce these campaigns.

12. The national chlamydia screening programme should be expedited and fully rolled out within the next two years. Chlamydia testing in all laboratories should be performed using NAATs technology.

Delivery: How Can We Deliver Better Services?

13. We strongly recommend that further quality points for sexual health are included as a priority in future development of the Quality and Outcomes Framework.

14. The IAG recommends availability of on the spot free pregnancy testing to facilitate an early diagnosis of pregnancy

15. While open access for all is our ultimate aim, it is essential that a 48-hour target for access to specialist GUM services is set by the Department of Health and that this should be a target upon which PCTs are measured and assessed.

16. Additional resources are required to ensure that all clinics have the necessary facilities and space

requirements to meet current and anticipated patient needs. It is important that the government provides continued support and investment in manpower and estate in order for GUM clinics to fulfil this role.

17. A full audit of targeted GUM funding should be performed. Specifically, the government must ensure that all of the recurrent funding targeted for GUM clinics reaches its intended recipients and is used to improve access to these services.

18. Performance management of PCTs' local commissioning groups and Local Delivery Plans should include access to contraception. Local commissioners must identify current patterns of provision both from primary care and community clinics and local needs for contraceptive services.

19. PCTs and Strategic Health Authorities must ensure that contraceptive services are fully funded and resourced, and should also undertake comprehensive data collection to evaluate and monitor service provision.

20. The Department of Health should review the staffing situation and take steps to ensure that adequate staff are available.

21. All PCTs should aim to commission adequate services to cover the full demand for abortion among their local population. All PCTs should have written protocols, service specifications or guidelines on good practice to cover all aspects of abortion services.

22. All PCTs should provide most abortions for local women in considerably less than the minimum national standard of three weeks from first appointment to abortion procedure. As a minimum, we recommend that at least 90% of abortions should be paid for by the NHS.

23. PCTs should ensure that women have access to early medical and surgical abortion.

24. Targeted campaigns highlighting the advantages of HIV testing should be implemented nationally and locally. In GUM clinics, HIV testing should be routinely offered and recommended to all patients and urgent consideration should be given to expanding HIV testing services in Primary Care and community settings.

25. PCTs should explore establishing integrated health and social care services created through partnerships between HIV treatment centres, local government and community organisations.

26. The role of the AIDS Support Grant (ASG) as a dedicated funding source for local authority HIV services has become increasingly important in ensuring that the development and integration of quality health and social care services. The ASG should be retained in order to support not only these planned changes but also the development of the skills necessary to appropriately meet the needs of the changing pattern of the HIV epidemic.

27. PCTs should commission and provide sexual health services which are adequately tailored to meet the needs of ethnic minority groups. Recognition of cultural need and language barriers with widespread use of link workers and interpreting services is vital. PCTs should invest in training for frontline staff in provision of culturally sensitive services, and postgraduate medical education training boards should include teaching and guidance on sexual health including ethnic minority healthcare issues in the medical school curriculum.

Research and Epidemiology: Getting a Clearer Picture

28. The Department of Health needs to conduct a mapping exercise to determine the range and quality of sexual health and HIV research in the UK, and whether the current division of labour with regard to funding is appropriate, with a view to increasing the resources available to what has been a neglected area of research support.

29. The Department of Health and MRC should work together with researchers and grant funding bodies to identify means by which more rapid progress can be achieved in supporting topics in which there is currently a dearth of submissions, notably the development and testing of interventions and diagnostic and technological innovation.

Annex II Activities during the year

Since its launch in 2003 the Independent Advisory Group for Sexual Health and HIV has met five times for full meetings, and has also held two further special meetings to discuss responses to the Health Select Committee's Report on Sexual Health and to the 'Choosing Health?' public health white paper consultation. A wide range of topics have been discussed and promoted covering key aspects of the Sexual Health Strategy implementation.

The IAG has also published two reports, a newsletter and issued press releases (available from the IAG's pages on the Department of Health website at www.dh.gov.uk). In addition, individual members of the IAG have attended conferences, made visits, and developed relationships with PCTs, SHAs and other professional and voluntary groups looking at all aspects of sexual health.

Full chronological details of the IAG's activities are given below:

6 March 2003	Department of Health press release.	Health Minister announces formation of IAG to advise on sexual health
6 May 2003	First meeting	• Terms of reference • Progress on the implementation of the Strategy • Future work priorities • Media and communications
21 July 2003	Special meeting	• Response to the Health Select Committee's Report on Sexual Health
23 September 2003	Second meeting	• Health Select Committee Report (update) • Baseline reviews of PCTs • Shifting the balance of power: national and local perspectives • The 'Sex Lottery' media campaign
15 December 2003	Third meeting	• Sexual health data • The IAG's first annual report • Sexual health promotion • Insurance and HIV
15 January 2004	Publication and press release	Response to the Health Select Committee Report on Sexual Health
June 2004	Submission of evidence	Submission of evidence to Department of Health '*Choosing Health?*' consultation

Annex III List of Members with Summary Biographies

Chair

Baroness Joyce Gould

Baroness Gould, Chair of the Independent Advisory Group on Sexual Health and HIV, is a House of Lords Life Peer with a strong interest in sexual health. She is President of fpa (formerly named Family Planning Association), patron of FORWARD, an organisation that campaigns against female genital mutilation and also Chair of the All Party Pro Choice and Sexual Health Group. She has extensive experience of chairing large groups and committees.

Joint Vice Chairs

Anne Weyman OBE

Anne Weyman is Chief Executive of fpa. She was involved in the development of the National Sexual Health and HIV Strategy and is also a member of the Independent Advisory Group on Teenage Pregnancy. She was formerly Information and Public Affairs Director at the National Children's Bureau. In 1987, she founded the Sex Education Forum and is now its President.

Derek Bodell

Formerly Chief Executive of the National AIDS Trust for nine years, Derek Bodell is acting as consultant on the development of the World AIDS Campaign and also works with an American group, Global Health Strategies, on NGO support for vaccines to benefit the needs of developing countries. He has over 15 years experience in delivering Sexual Health and HIV services at both a strategic and local level, contributing to policy issues within the UK, Europe and internationally. He also served as a member of the Sexual Health and HIV Steering Group and was involved in developing specific proposals in 1997 for the integration of HIV into a broader sexual health framework. He has extensive experience of chairing and facilitating groups, including as Chair of Stop Aids Campaign (SAC) and as an advisor on the World AIDS Campaign for UNAIDS.

Strategy and Implementation Special Adviser

Michael Adler CBE

Michael Adler is Professor of Genitourinary Medicine, Royal Free and University Medical School and was seconded to the Department of Health until 2001 to take a lead on the development of the Sexual Health and HIV Strategy. He is an advisor to the All Party Group on AIDS, and the Health Select Committee. He has also served as a Trustee and Chairman of the National AIDS Trust (NAT), and as Clinical Director of HIV/AIDS/GUM and Drugs Services for both Bloomsbury and the Camden Community Health Services. He has been a non-executive director of the Health Development Agency since 1999.

Senior Health Promotion Expert

Jo Adams

Jo Adams is the Director of the Centre for HIV and Sexual Health and chair of the National Sex Education Forum. She was a member of the Sexual Health Strategy Steering Group, which helped develop the Sexual Health and HIV Strategy, chaired the Strategy's Sexual Health Promotion Working Group and wrote the Effective Health Promotion Toolkit. Jo has a particular interest in training to support sexual health and HIV work, youth work and has written a number of manuals and handbooks for practitioners.

Public Health Expert

Kevin Fenton

Kevin Fenton is Consultant Epidemiologist and Head of HIV/STI Section at the Public Health Laboratory Service. He has been actively involved in many aspects of the development and implementation of the Sexual Health and HIV Strategy including sitting on a number of the working groups. He currently chairs the Chlamydia Screening Programme Steering Group. He has also been involved with a number of research studies, which have informed the development of the strategy, including the National Survey of Sexual Attitudes and Lifestyles.

General Practitioners

William Ford-Young

William Ford-Young has been a "grass roots" GP for 15 years in Macclesfield, during which time his interest in sexual health and HIV has been developed with concurrent work in GUM clinics, He is currently the Lead for Sexual Health and HIV for Eastern Cheshire PCT, Chairs the Royal College of General Practitioners' Task Group for Sex, drugs and HIV, is the GP member of the National Chlamydia Screening Programme Steering Group at the Department of Health and the GP member of the Health Protection Agency Advisory Committee on STDs. He is now on a part time secondment as a GP Fellow in Public Health, which links his PCT role with studying for a Diploma in Applied Public Health at Liverpool John Moores University.

Surinder Singh

Surinder Singh is a General Practitioner and Clinical Lecturer in General Practice at the Royal Free and University College Medical School. He has worked in the area of sexual health and HIV/AIDs since 1987. He was previously Chairman of the Royal College of General Practitioners Working Party on HIV/AIDS and is now a member of the same committee and is also a member of the Expert Advisory Group on AIDS and Advisory Group on blood-borne Viruses. He has written various articles on sexual health and HIV infection, and has extensive experience of service planning and provision at both a strategic and local level.

Consultants in Family Planning/Community Gynaecology

Connie Smith

Connie Smith is a co- director of Westside Contraceptive Services working with the Department of Health on Strategy implementation. She is an adviser to the Medicines and Healthcare Regulatory Agency and the Committee on Safety on Medicines on contraception issues.

Sunanda Gupta

Sunanda Gupta is Clinical and Professional lead in Family Planning and Reproductive Healthcare at Waltham Forest Primary Care Trust. This incorporates complex contraception provision, unintended pregnancy and vasectomy services, community cervical cytology, colposcopy and HRT/menopause services. A member of the Trust Clinical governance sub – committee, she has led her department through a number of changes and developments – including PCT reconfiguration, Teenage Pregnancy and National Sexual Health Strategy. She is an active member of Waltham Forest Sexual Health Forum, and a founder member of the Faculty of Family Planning and Reproductive Healthcare of the RCOG, having served on the Examination and Higher Training Committees of the Faculty of Family Planning. She is on the Board of Directors of International Society of Advancement in Reproductive Healthcare. She is also Honorary Clinical Lecturer at Barts and Queen Mary's School of Medicine London and has published a variety of research, review articles, journals and book chapters.

Consultants in Genito-Urinary Medicine

Patrick French (specialist in HIV treatment and care)

Patrick French is currently Consultant in Genito-Urinary Medicine at Camden PCT, Honorary Senior Lecturer at the Royal Free University College Medical School and Honorary Consultant Physician at the Whittington and UCLH Trusts. He was involved in the development of the Sexual Health and HIV Strategy as a member of the Steering Group. He also took responsibility for developing the Strategy's approach to strengthening and modernising sexual health treatment and care services.

George Kinghorn (generalist)

George Kinghorn has been a Consultant in Genito-Urinary Medicine, Clinical Director for Communicable Diseases and a full time lead for clinical teaching and research in Sheffield since 1979. He is involved in a variety of local, regional and national initiatives including being the immediate past President of the Medical Society for the Study of Venereal Diseases (MSSVD). He was the main author of the genito –urinary medicine response to the consultation on the Sexual Health and HIV Strategy.

Nurses

Kathy French

Currently a part time sexual health advisor at the Royal College of Nursing, Kathy French is working on a distance learning skills for nurses that has been commissioned by the Department of Health. Her previous position was as Clinical Nurse Manager for Contraception and Termination of Pregnancy Services at Kings Healthcare in London and Clinical Nurse Specialist in contraception. She is undertaking a PHD in teenage pregnancy and the invisibility of young males. She continues to do locum work to maintain clinical skills and knowledge.

Lesley Greenhalgh

Lesley Greenhalgh is a lecturer in adult nursing at the University of Salford, with extensive knowledge and clinical experience in sexual health underpinned by professional qualifications. She is the teaching and learning lead on the board of the Greater Manchester sexual health network and a member of the Institute of City and Guilds, and was awarded a Diploma for Leadership in nursing for her contribution to the higher level of practice pilot study. Currently undertaking an MSC in strategic leadership at the University of Salford, Lesley is a member of the Genito Urinary Nurses Association and the British Association for Sexual Health and HIV (BASHH).

Sexual Health Adviser

Heather Wilson

Heather Wilson is a Senior Health Adviser at Barnet Hospital. She has a background in social work and has been a sexual health advisor since 1989. Heather was President of the Society for Sexual Health Advisors in Sexually Transmitted Diseases (SHASTD) from 1998-2. She has extensive knowledge of STIs and HIV, and was one of the health advisors on the working party that informed the Sexual Health Strategy. She also was one of the authors of the Manual for Sexual Health Advisors, commissioned by the Department of Health as one of the action points of the Strategy.

Abortion Providers

Ian Jones

Until recently Chief Executive of the British Pregnancy Advisory Service, Ian Jones has contributed throughout the consultation period of the Sexual Health and HIV Strategy and the earlier Social Exclusion report on Teenage Pregnancy. He also has contributed to various Department of Health Working Parties, including the expert Group on the use of Conscious Sedation and more recently gave evidence to the House of Commons Health Committee enquiry into the Strategy.

Helen Axby

Helen Axby is Deputy Chief Executive of Marie Stopes International with 18 years experience including working directly with clients and service providers. As part of this role she has undertaken international work and worked alongside various international Ministries of Health, contributing to policy development including the recent legislation of abortion in Nepal. Other projects have included developing contractual agreements between the NHS and the non-government sector, service development including early medical abortion, the introduction of local anaesthetic and the management of late abortion.

Primary Care Trust – Chief Executive

Joanne Forrest

Currently Chief Executive of North Liverpool PCT, Joanne Forrest has over 20 years experience within the NHS as both a clinician and a manager. She is lead commissioner of sexual health services of all Liverpool and Sefton. As part of this role she has responsibility for other related areas including teenage pregnancy, termination services and prison health. She is also Chair of the Liverpool and Sefton Sexual Health Strategy Implementation Group.

Strategic Health Authority Director

Sheila Adam

Sheila Adam is Director of Public Health for North East London Strategic Health Authority and has in the past worked at both regional and national level. Until

recently she was Deputy Chief Medical Officer and co-chaired, with Michael Adler, the Sexual Health and HIV Strategy Steering Group and was involved in the Strategy's development and launch. She was a Medical Research Council Training Fellow, a Visiting Professor at the London School of Hygiene and Tropical Medicine and is currently an Honorary Professor at Queen Mary University, London.

Social Services Manager

Stephen Slack

For the past eight years Stephen Slack has worked within the area of sexual health for the Social Services Department in Sheffield, initially as a specialist social worker for people with HIV before taking the role of Team Manager for the HIV Social Work Team and Lead Officer for Sexual Health. He has written local sexual health policy, based on the Sexual Health and HIV Strategy, which is being implemented. Stephen is also involved in regional HIV training.

User and Self Help Group Representatives

Christopher Woolls

Christopher Woolls is currently the Director of Staffordshire Buddies, a charity that provides support and care to people with HIV/AIDS. He worked in partnership with key local stakeholders, including people living with HIV, to formulate responses to the Sexual Health Strategy. Previously, he was Health Promotion Manager at Terrence Higgins Trust South. He has lived with HIV for the last ten years, and has an extensive knowledge and understanding of the issues people face with the condition.

Voluntary Sector

Jan Barlow

Jan Barlow is the Chief Executive of Brook Advisory Services, an organisation which aims to protect, promote and preserve the sexual and reproductive health of young people. She has over five years senior management experience in the voluntary sector in both large and smaller organisations. She was a member of a Sexual Health and HIV Strategy sub-group and was responsible for drafting a formal response to the Strategy. Brook Advisory was also commissioned by the Department of Health to undertake a consultation with young people on the Strategy.

Nicholas Partridge

Nicholas Partridge is Chief Executive of Terrence Higgins Trust and has worked in the HIV/AIDS field since 1985. He has overseen the development, implementation and monitoring of HIV and STI prevention programmes, as well as the creation and delivery of a wide range of social care and advice services for people living with HIV. He was a member of the Sexual Health and HIV Strategy Steering Group and is a member of the Healthcare Commission.

Evelyn Asante-Mensah

Evelyn Asante-Mensah is Chief Executive of the Black Health Agency, an organisation that focuses on the needs of the black and minority ethnic communities in Manchester. She has worked in the sexual health and HIV field in a senior management capacity for the last 8 years and has experience of service delivery as well as developing policy. She was involved in the development of the Manchester Sexual Health Strategy as well as being involved in the Health Promotion Sub Group of the national Sexual Health and HIV Strategy working group. She is also the Chair of both Central Manchester PCT and Manchester Health Inequalities Partnerships which has responsibility for commissioning services to tackle inequalities in Manchester from statutory and non-statutory providers.

Elisabeth Crafer

Elisabeth Crafer is Chief Executive of Positively Women, a London based national organisation providing peer support to women living with HIV. She was a member of the Sexual Health Strategy Steering Group and the National HIV/AIDS Strategy Social Care group. She is also chair of the pan-London HIV Providers Consortium with 48 member organisations. She has also provided evidence to the All Party Parliamentary Group on AIDS, providing parliamentarians with evidence on issues affecting women and children.

Adviser on Black and Minority Ethnic Communities

Max Sesay

Max Sesay is currently Chief Executive of the African HIV Policy Network, an organisation that is responsible for representing Africans and black communities with HIV, as a result of this he has a firm grasp of the issues that affect these people. He was a member of Sexual Health Strategy Steering Group and responsible for organising Strategy Consultation events with African Communities.

Laura Serrant-Green

Laura Serrant-Green is a lecturer in Adult Health at the University of Nottingham. A member of the black community, she has worked in a variety of posts related to sexual health and HIV/AIDs since 1986. These include nursing, outreach working, lecturing, research and the training of HIV nurse/outreach worker capacity and as a mentor to black youth. She has been interviewed on behalf of local and national television, radio and newspapers about sexual health, HIV and black communities, and is also currently a member of the Royal College of Nursing Sexual Health Forum and Advisory Group on Sexual Health.

Researcher

Graham Hart

Graham Hart has worked in the sexual health field since 1986 and has been researching, teaching and contributing to policy since this time. A medical sociologist by background, his current post is Associate Director of the Medical Research Council Social and Public Health Services Unit at the University of Glasgow. Professor Hart has published an extensive range of research articles, chapters and edited books, as well as serving on international scientific committees. He chairs a number of national committees, including the Department of Health Teenage Pregnancy Evaluation Advisory Committee, the Medical Research Council/Department of Health Sexual Health and HIV Research Strategy Committee, and the Medical Research Council Special Training Fellowships in Health Services and Health of the Public Research Panel.

Annex IV Register of members' interests

	Personal interests		Non-personal interests	
Member	**Company**	**Interest**	**Company**	**Interest**
Baroness Joyce Gould	Family Planning Association	President		
	FORWARD	Patron		
	All Party Pro Choice & Sexual Health Group	Chair		
Lesley Greenhalgh	Greater Manchester Sexual Health Network	Board Member & Teaching and Learning Lead	British Association of Sexual Health & HIV	Member
			Genital Urinary Nursing Association	Member
Dr George Kinghorn	GlaxoSmithKline	Undertaking clinical research for a new herpes simplex virus vaccine as the principal UK investigator.	British Association of Sexual Health and HIV	Board Member and Trustee
			Medical Research Council	Sexual Health and HIV Research Committee Member
			Providers of AIDS Care and Treatment (PACT)	National Executive Member
			Medical Foundation for Sexual Health and HIV	Trustee
Evelyn Assant Mensah	Royal Society of Arts	Fellow		
	Black Health Agency	Chief Executive		
	Central Manchester Primary Care Trust	Chair		
	Manchester Health Inequalities Partnership	Chair		
	Manchester Joint Health Unit	Board member		

	Personal interests		Non-personal interests	
Member	**Company**	**Interest**	**Company**	**Interest**
Kevin Fenton	WHO Regional Office for Europe Consultancy	Consultancy	African HIV Policy Network	Board Member
			National AIDS Trust	Trustee
	Health Development Agency	Consultancy		
Derek Bodell	Global Health Strategies New York	Consultancy		
	Generic vaccines and Community relations	Consultancy		
Connie Smith	Family Planning Association	Member and donor		
Sheila Adam	Family Planning Association	Member and donor		
	DWCA – Doctors for a Woman's Choice on Abortion	Member		
	Mildmay Mission	Member and donor		
	*Partner, John Mitchell, with Sheila Damon manages Mitchell Damon, an OD consultancy which works with the public and voluntary sectors, predominantly in health care.			
Sunanda Gupta			Faculty of family planning and reproductive healthcare	Member
			International society of advancement Board In Reproductive care	Board

	Personal interests		Non-personal interests	
Member	**Company**	**Interest**	**Company**	**Interest**
Anne Weyman	Family Planning Association	Chief Executive	Independent Advisory Group on Teenage Pregnancy	Member
	Islington Primary Care Trust	Non Executive Director		
Max Sesay	African HIV Policy Network	Chief Executive Officer		
Dr Mike Adler	MEDFASH	Advisor	Health Development Agency	Non-executive Director
Graham Hart			MRC Sexual Health & HIV Research Strategic Committee	Chair
			Africa Centre for Population Health	Member of International Scientific Advisory Board
			Teenage Pregnancy Evaluation: Research Advisory Group	Chair
Jan Barlow	Brook Advisory Centres	Chief Executive	Independent Advisory Group on Teenage Pregnancy	Member
Jo Adams	Adams Painter Associates	Partner	Centre for HIV & Sexual Health	Director
	GW Pharmaceuticals	Ordinary Shareholder	Sex Education Forum	Chair
			Sheena Amos Youth Charitable Trust	Chair
			Parent to Parent Charitable Trust	Trustee
			National Sexual Health Training Strategy Group	Chair

	Personal interests		Non-personal interests	
Member	**Company**	**Interest**	**Company**	**Interest**
William Ford-Young	Glaxosmithkline AstraZeneca	Ordinary shareholder Ordinary shareholder		
Surinder Singh	None declared	None declared	None declared	None declared
Patrick French	None declared	None declared	None declared	None declared
Kathy French	None declared	None declared	None declared	None declared
Heather Wilson	None declared	None declared	None declared	None declared
Ian Jones	None declared	None declared	None declared	None declared
Helen Axby	None declared	None declared	None declared	None declared
Joanne Forrest	None declared	None declared	None declared	None declared
Stephen Slack	None declared	None declared	None declared	None declared
Christopher Woolls	Staffordshire Buddies Network of Self Help HIV/AIDS Groups	Director Trustee		
Nicholas Partridge	None declared	None declared	None declared	None declared
Elisabeth Crafer	None declared	None declared	None declared	None declared
Laura Serrant-Green	None declared	None declared	None declared	None declared

Annex VI Glossary of Terms

AIDS	Acquired Immune Deficiency Syndrome
BASHH	British Association for Sexual Health and HIV
BME	Black and minority ethnic
CHAPS	Community HIV & AIDS Prevention Strategy
EIA	Enzyme Immuno Assay (chlamydia test)
FORWARD	Foundation of Women's Health, Research and Development
GMS	General Medical Services
GP	General Practitioner
GPRD	General Practitioner Research Database
GUM	Genito-Urinary Medicine
HIV	Human immunodeficiency virus
IUD	Intrauterine device
IUS	Intrauterine system
HPA	Health Protection Agency
LOC	Letter of Competence
MedFASH	Medical Foundation for Sexual Health
MRC	Medical Research Council
MRCSHHRSC	Medical Research Council Sexual Health and HIV Research Strategy Committee
MSM	Men who have Sex with Men
NAATs	Nucleic Acid Amplification Tests (chlamydia test)
NHS	National Health Service
NpfIT	National Programme for Information Technology
PCO	Primary Care Organisation
PCT	Primary Care Trust
PSHE	Personal, Social and Health Education
QOF	Quality Outcomes Framework
RCGP	Royal College of General Practitioners
RCOG	Royal College of Obstetricians and Gynaecologists
RCN	Royal College of Nursing
SHA	Strategic Health Authority
SRE	Sex and Relationships Education
STI	Sexually Transmitted Infection

DH Department of Health

Independent Advisory Group
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